CERTIFICATE OF VISION EXAMINATION BY COMPETENT AUTHORITY

MV3030V 6/2000 Ch. 343 Wis. Stats.

Wisconsin Department of Transportation
Medical Review Unit
PO Box 7918, Madison, WI 53707-7918

Clear Form

Operator License Number			
Applicant Name	Birth Date	Area Code-Telephone Number	
Street Address	City	Zip Code	Application Held At
Date Issued	Examiner Badge Number	Application Type: ☐ Operator ☐ CDL ☐ Passenger ☐ School Bus ☐ Instruction Permit	

NOTE TO APPLICANT: Once this vision report has been reviewed, you may be required to file vision reports on a regular basis. We will send you the forms at the time they are required.

Note to Reporting Vision Specialist: All parts of this form must be completed to avoid delay. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Your report will be advisory in determining eligibility.

NOTE: VISION EXAMINATION MUST HAVE BEEN CONDUCTED WITHIN THE PAST 90 DAYS.

Please answer each of the following questions:

	Yes	No
1. Is applicant able to distinguish traffic signal colors of red, amber, and green?	☐	☐
2. Are there any progressive eye conditions?	☐	☐

Answer the following (if applicable):

Right Eye	Left Eye	
☐	☐	a. Cataracts present?
☐	☐	b. Cataracts removed?
☐	☐	c. Macular degeneration?
☐	☐	d. Retinitis pigmentosa?
☐	☐	e. Diabetic retinopathy?
☐	☐	f. Glaucoma?
☐	☐	g. Other progressive?

Indicate Snellen Chart Figures

Visual Acuity	Without RX	With RX	**REQUIRED** Temporal Field of Vision in Degrees
Right Eye	20/	20/	
Left Eye	20/	20/	

Explanation of each checked question (Please Print)

3. Comments (Please Print)

4. In your opinion, is this person able to drive safely?
   - ☐ Yes
   - ☐ No
   - ☐ Only if a road test is passed

5. Please indicate recommended restrictions
   - ☐ Corrective Lenses
   - ☐ Daylight Driving Only
   - ☐ _____ Miles From Home
   - ☐ Other (Please Print) _____

Examining Authority Name (Please Print)	License Number
Office Address	Office Telephone Number

FOR OFFICE USE ONLY

Review Date

Bureau Representative

- ☐ Approved
- ☐ Disapproved
- ☐ More Information Required
- ☐ Driving Evaluation Required

Follow-up
- ☐ 6 Months
- ☐ 12 Months
- ☐ 24 Months
- ☐ None

I certify that I have examined this applicant's vision within the past 90 days and I am licensed to practice

- ☐ **medicine**
- ☐ **optometry.**

Examining Authority Signature	**Vision Examination Date**
X	